

**Family Planning Program
HIV CTR Form/ABCD Client Survey
Reporting Requirements**

In Rhode Island, HIV CTR services are considered to be "core" Title X family planning service. A Family Planning Program HIV CTR form must be completed on every client who receives HIV CTR services through this program. In addition, the Family Planning Program will reimburse agencies that provide HIV CTR services to pregnant clients, regardless of when they receive those services during their pregnancy.

The completed HIV CTR forms should be mailed to the Rhode Island Department of Health (HEALTH), 3 Capitol Hill, Room 302, Providence, RI 02908, c/o Phanida Khamsomphou. The Family Planning Program will return all incomplete or incorrect HIV CTR forms to your agency for correction. In order to ensure the proper documentation, please review the following guidelines.

PART I - HIV CTR Form Reporting Requirements

Item Number 1 Client Number: For confidential HIV CTR clients, the client number should be the client's medical record number. In other words, the client number on the FPER and the client number of the HIV CTR form should be the same number. For anonymous HIV CTR clients, the client number should be the client's assigned anonymous number.

Item Number 2 Project Number: Every HIV CTR form must have the agencies four-digit family planning project number.

Item Number 3 Site Number: Every HIV CTR form must have the agencies four-digit family planning site number.

Item Number 4 Date of Visit: Every HIV CTR form must have the date of visit completed.

Item Number 5 Sex: Every HIV CTR form must have the sex of the client completed.

Item Number 6 Health Insurance Provider: Health Insurance Provider must be completed as follows:

- Select NONE, if the client is a no cost, partial or full fee;
- Select SELF, if the client pays for private health insurance;
- Select PUBLIC ASSISTANCE, if the client has Rite Care, Rite Share, and Medicaid;
- Select MILITARY/VA, if the client uses military health insurance;
- Select EMPLOYER, if the client is privately insured by their employer.

Item Number 7 Age: Every HIV CTR form must have the age of the client.

Item Number 8 Ethnicity: For Ethnicity, either Hispanic/Latino or Not Hispanic/Latino must be selected.

Item Number 9 Race: For Race, one or more than one race must be selected. If a word is written i.e. Cape Verdian in place of checking on or more of the races provided, then the HIV CTR form will be sent back for correction.

Item Number 10 Zip Code: This item must be completed for all clients, even those who decline testing.

Item Number 11 Reason for Visit: This item must be completed for all clients, even those who decline testing.

Item Number 12 Since 1978: If applicable, this item must be completed for all clients, including those who decline testing.

Item Number 13 Sexual Relations with: This item must be completed for all clients, even those who decline testing.

Item Number 14 Client Previously Tested: Select one item. This item must be completed for all clients, even those who decline testing.

Item Number 15 Indicate Test Type: Select One Item.

- Select ANONYMOUS STANDARD for clients who have an anonymous (i.e. client's name cannot be linked to the sample) venous blood sample (ELISA) or oral fluid sample (Orasure) sent to a lab for the detection of HIV antibodies.
- Select CONFIDENTIAL STANDARD for clients who have a confidential venous blood sample (ELISA) or oral fluid sample (Orasure) sent to a lab for the detection of HIV antibodies.
- Select ANONYMOUS RAPID for clients who have an anonymous (i.e. client's name cannot be linked to the sample) blood, fingerstick or oral fluid sample collected for same-day detection of HIV antibodies. (e.g. Oraquik)
- Select CONFIDENTIAL RAPID for clients who have a confidential blood, fingerstick or oral fluid sample collected for same-day detection of HIV antibodies. (e.g. Oraquik)
- Select CLIENT DECLINED TESTING THIS VISIT if the client refused testing services but received HIV counseling.

Please note: only Family Health Services and VNS of Newport are currently providing anonymous testing. Even in these agencies, some clients may be confidential HIV CTR clients. When a patient has an anonymous HIV test, he/she is given a number and no one asks for, or knows, his/her name. When a patient has a confidential HIV test, his/her test results may be put in his/her medical record.

Item Number 16 If Not Tested, Indicate Reason: Select one item for clients who DECLINE testing only. OTHER can be used for clients who receive HIV education and

have no risk factors (for example, a young teen who has never engaged in sexual activity) or a client who fails to show up for the necessary lab work. If a client has an HIV test, this item should be left BLANK.

Item Number 17 Test Results: This section should be completed for all clients who are tested. Select two for clients who undergo rapid testing and have a preliminary positive result.

- Select NEGATIVE if a standard test **OR** a rapid test was administered and no HIV antibodies were detected in the specimen;
- Select POSITIVE if a standard test was administered and HIV antibodies were found in the specimen; **OR** a preliminary positive (i.e. unconfirmed) rapid test detected HIV antibodies in the specimen. If it was a Positive Rapid test result then you must also choose one from the following two below:
 - Select POSITIVE RAPID CONFIRMED POSITIVE if a rapid test was administered and the preliminary positive result was confirmed to be positive from the specimen.
 - Select POSITIVE RAPID CONFIRMED NEGATIVE if a rapid test was administered and the preliminary positive result was confirmed to be negative from the specimen
- Select INCONCLUSIVE if a standard or rapid test was administered and it could not be determined if HIV antibodies were found in the specimen.
- Select NO RESULT if a standard or rapid test was administered and the results were lost by the lab or agency.

Item Number 18 Post Test Counseling: Select one item. This item must be completed for all clients, even those who decline testing.

Item Number 19 Date of Post Test Counseling: This section should be completed for all clients who received HIV testing and who showed up for post-test counseling. The date noted should be the date that the actual post-test counseling took place.

Item Number 20 If Positive, Referral Provided: Select one or more items. This item must be completed for all clients, even those who decline testing

For the existing state-funded HIV anonymous testing site (i.e. Family Health Services), they may use the CDC "bubble" form instead of the HIV CTR form. This agency should bill HEALTH's HIV/AIDS Program for any client who receives HIV CTR services only and bill HEALTH's Family Planning Program for any client who receives another family planning service or services (including STD services), in addition to HIV CTR services.

All agencies should hold the HIV CTR form for three months following the client's test date for clients who fail to show up for post-test counseling to assure that the client has adequate time to re-contact the agency for their test results. All agencies must have appropriate written protocols in place to follow-up on clients who have a positive HIV test result.

For clients who initially fail to show up for post-counseling but do so after the agency has forwarded the HIV CTR form to HEALTH, please either fill out another form with the completed post-counseling information on it.

In addition, you must complete an FPER form for every client who receives confidential HIV CTR services. For anonymous HIV CTR services, if the family planning patient receives family planning services on the day of the anonymous HIV test, then complete an FPER for the family planning services, but not including the HIV test.

PART II – ABCD Client Survey Reporting Requirements

Providers are required to counsel clients on the ABCD method of HIV prevention at every **new** visit date. After receiving counseling, the client must fill out the ABCD Client Survey on the reverse side of the HIV CTR form. HIV CTR forms with incomplete or improperly filled out surveys will be returned to the agency for corrections. Clients must be highly encouraged to participate in the survey at each new visit.

Question Number 1 and 2: This section should be filled out if the client has received counseling on the ABCD Method *for the first time* at that visit. These questions gauge the client's understanding of the ABCD Method and if they plan to implement it in their lives.

Question Number 3 and 4: This section should be filled out if the client has received counseling on the ABCD Method *at a previous* visit. These questions assess if the client was able to successfully implement the ABCD Method, and/or the reasons they were not successful. Please remember that questions 3 and 4 are not to be completed at the post-test counseling visit (for clients who receive testing) but at each new future visit date.

Ordering More HIV CTR Forms

There are four easy ways to order HIV CTR Forms or any other materials from the Family Planning Program:

- 1) Complete a Family Planning Program Education Materials Order Form and mail to:

Distribution Center
Rhode Island Department of Health
Three Capitol Hill, Room 302
Providence, RI 02908-5097
- 2) Submit your request online at: <http://kidsnet.health.ri.gov/forms/>
- 3) Phone your request: 1-800-942-7434
- 4) Fax your request: 401-222-1442 (Attn: Distribution Center)